HD-0719-1011

NEW JERSEY EMPLOYEE DENTAL PLANS APPLICATION

Division of Pension and Benefits, P.O. Box 299,Trenton, NJ 08625-0299

DIVISION USE ONLY

Effective Dates: D _____ _____ _____ Event Reason: ____

EMPLOYER CERTIFICATION
See instructions on reverse

Employer Name:_____

Payroll # (State Biweekly) ____ Union Code (Rx) Only ____

Location # (State Monthly or Local/Educational) ____ - ____

10/12 month employee (Enter "10" or "12") ____

MEMBER ACTION

☐ New Enrollment ☐ Transfer

Date Employment Began _____/_____/_____ (mm/dd/yy)

☐ Return from Leave of Absence _____/_____/_____

_____
Signature of Certifying Officer

_____
Telephone # Date Mailed

1. EMPLOYEE INFORMATION-This section must be filled out completely. Please print or type.

Social Security Number ___ - ___ - ____

Last Name _____ Title (Jr., Sr., etc.) ____

First Name _____ MI ____

Street Address (Include Apartment #) _____

City _____ State ____

ZIP Code + 4 _____ - _____ Date of Birth (mm/dd/yy) _____ Gender (M/F) ____

Status:

☐ -Single ☐ -Married ☐ -Civil Union ☐ -Domestic Partnership ☐ -Divorced ☐ -Widowed

Are you transferring from another SHBP/SEHBP participating employer? ☐ Yes ☐ No

(Area Code) Home Telephone Number ___ - ___ - ____

If yes, name of employer: _____

2. DENTAL COVERAGE

2a. EMPLOYEE SELECTION (You must remain enrolled in the Dental Plan for a minimum of 12 months)

☐ I wish to be covered under the Dental Expense Plan.

☐ I wish to be covered under a Dental Plan Organization (DPO).

_____ _____
Name of DPO DPO#

_____
Name of Dentist or ID#

☐ I am changing dental plans only:

From _____

To _____

☐ I elect to waive dental coverage in any dental plan (see instructions).

2b. LEVEL OF COVERAGE

☐ Single ☐ Member and Spouse/Civil Union Partner

☐ Member and Domestic Partner (see instructions)

☐ Family ☐ Parent and Child(ren)

3. DEPENDENT INFORMATION - List only eligible dependents and attach required proof of dependency documents (see instructions on reverse).

Spouse/Civil Union/Domestic Partner / Children	Last Name	First Name	MI	Date of Birth (mm/dd/yy)	Gender (M/F)	Social Security Number	Name of Dependent's Dentist or ID#	Natural (C) Adopted (A) Foster (F) Step (S) Legal Ward (L) See Instructions
						___ - ___ - ____		
						___ - ___ - ____		
						___ - ___ - ____		
						___ - ___ - ____		
						___ - ___ - ____		

4. TYPE OF ACTIVITY
(complete only if requesting changes to existing coverage)

4a. ADDITION OF DEPENDENT
(attach required proof of dependency documentation)

☐ Marriage
Date of Event (mm/dd/yy) _____
(attach Marriage Certificate and supporting documents)

Former Name _____

☐ Civil Union/Domestic Partner - Date of Event (mm/dd/yy) _____
(attach Certificate of Civil Union or Domestic Partnership and supporting documents)

☐ Birth of Child (attach supporting documents)

☐ Adoption/Guardianship - proof required
Date of Event (mm/dd/yy) _____

4b. DELETION OF SPOUSE OR PARTNER

☐ Divorce ☐ Dissolution of Civil Union

☐ Termination of Domestic Partnership ☐ Death

Date of Event (mm/dd/yy) _____

4c. DELETION OF CHILD

☐ Deletion of Child -

Date of Event (mm/dd/yy) _____

Child's Name _____

Child's SSN _____

Give Reason _____

4d. OTHER CHANGES

☐ Change in last name only
(Attach copy of supporting documentation)

(List former name) _____

☐ Change in Soc. Sec. #
(Attach copy of Social Security card)

(List former Soc. Sec. #) _____

☐ Change in Birth Date
(Attach copy of birth certificate) (List name and correct date)

_____

☐ Other - give reason (i.e., address change, dependent returns from military service) _____

_____

5. EMPLOYEE CERTIFICATION - I certify that all the information supplied on this form is true to the best of my knowledge and that it is verifiable. I understand that if I waive my right to coverage at this time, enrollment is not permissible until the next scheduled open enrollment or if other coverage is lost and proof of loss is provided (HIPAA). I understand that I must remain enrolled in the Dental Plan for a minimum of 12 months and that there is no guarantee of continuous participation by dental service providers, either dentists or facilities in the DPO plans. If either my dentist or dental center terminates participation in my selected plan, I must select another dentist or dental center participating in that plan to receive the "in-network" benefit. I authorize any hospital, physician, dentist, or dental care provider to furnish my dental plan or its assignee with such dental information about myself or my covered dependents as the assignee may require.

Misrepresentation: Any person that knowingly provides false or misleading information is subject to criminal and civil penalties.

Employee Signature _____

Date Completed _____

INSTRUCTIONS FOR THE EMPLOYEE DENTAL PLANS APPLICATION

- **To change your dentist** with your DPO, contact your dental plan directly. **DO NOT COMPLETE THIS FORM JUST TO CHANGE YOUR DENTIST.**
- **To enroll** for the first time complete all sections of the application with the exception of section 6.
- **To change dental plans only** complete sections: 1, 2a and 2b (if enrolling in a DPO be sure to list the name of your dentist or his/her identification number), 3 (listing all eligible dependents), and 5.
- **To change coverage level** (adding/deleting dependents) complete sections: 1, 2a and 2b, 3 (listing all eligible dependents), 4 (listing why you are changing coverage level), and 5.
- **To add a dependent** complete sections: 1, 2a and 2b, 3 (listing all eligible dependents), 4a, and 5. You must also attach the required proof of dependency documents.
- **To terminate/decline coverage** complete sections: 1, 2a, and 5. If you are declining enrollment for yourself or any or all of your eligible dependents because of other group dental insurance coverage, you may in the future be able to enroll yourself and/or your eligible dependents in a dental plan, provided that you request enrollment within 60 days after your other group health coverage ends.

SECTION 1 - EMPLOYEE INFORMATION

This section is completed in its entirety each time an application is submitted. The employee enrolling/enrolled in the plan completes this section.

SECTION 2 - DENTAL COVERAGE

2a. Check only one box indicating the dental plan you wish to be enrolled in. If you do not want dental coverage or wish to cancel coverage, check the box to waive coverage.

NOTE: Once you decline or cancel Medical, Prescription Drug, or Dental coverage, enrollment is not permissible until the next open enrollment period or if other coverage is lost and proof of loss is provided (HIPAA).

2b. If electing coverage, check the level of coverage desired. (No employee or dependent can be covered under more than one Dental Plan.)

NOTE: Once enrolled, you and your eligible dependents must remain in the plan you elect for a minimum of 12 months before you can switch plans or drop coverage.

SECTION 3 - DEPENDENT INFORMATION — Only eligible dependents may be listed. Completion of this section is essential for proper enrollment. Be sure dependents listed agree with the level of coverage selected in sections 2b. List the name, date of birth, gender, and Social Security number of the family members you wish to be covered under the plan. You may list an eligible spouse, civil union partner, or same-sex domestic partner, and your children under age 26.

SPOUSE: This is a person of the opposite sex to whom you are legally married. A photocopy of the *Marriage Certificate* **and** a photocopy of the employee's most recent Federal tax return* that includes the spouse are required for enrollment.

CIVIL UNION PARTNER: This is a person of the same sex with whom you have entered into a civil union. A photocopy of the New Jersey *Civil Union Certificate* or a valid certification from another jurisdiction that recognizes same-sex civil unions **and** a photocopy of the employee's most recent NJ tax return* that includes the partner are required for enrollment. The cost of civil union partner coverage may be subject to federal tax (see your employer or Fact Sheet #75, *Civil Unions,* for details).

DOMESTIC PARTNER: This is a same-sex domestic partner, as defined under Chapter 246, P.L. 2003, the Domestic Partnership Act, of any State employee, State retiree, or an eligible employee or retiree of a SHBP or SEHBP participating local public entity if the local governing body adopts a resolution to provide Chapter 246 health benefits. A photocopy of the New Jersey *Certificate of Domestic Partnership* dated prior to February 19, 2007 or a valid certification from another jurisdiction that recognizes same-sex domestic partners **and** a photocopy of the employee's most recent NJ tax return* that includes the partner are required for enrollment. The cost of same-sex domestic partner coverage may be subject to federal tax (see your employer or Fact Sheet #71, *Benefits Under the Domestic Partnership Act,* for details).

***Note:** On tax forms you may black out all financial information and all but the last 4 digits of any Social Security numbers.

CHILDREN: This is your child under age 26. A photocopy of a child's birth certificate showing the name of the employee as a parent is required for enrollment. In addition, if you have listed a child who is an adopted child, foster child, stepchild, legal ward, has a different last name than the employee, or if the member has a Parent/Child contract, additional supporting documentation is required. If you have more than four eligible dependent children, attach a separate application and complete Sections 1, 3, and 5. For all dependents, include the dentist's name or identification number. All dependents must have this information listed. Refer to the DPO directory for this information or call the dental plan directly.

NOTE: If you are deleting dependents, do not list them in this section. Refer to section 4b and 4c.

SECTION 4 - TYPE OF ACTIVITY

4a. If you are adding a dependent, check the appropriate box, indicate the event date, and attach required proof of dependency documentation.

4b. If you are deleting a dependent spouse, civil union partner, or domestic partner, check reason and indicate the event date.

4c. If you are deleting a dependent child, indicate the event date, list the child's Social Security number, and give reason.

4d. For other changes, check the appropriate box, give requested information, and attach a copy of supporting documentation if applicable.

SECTION 5 - EMPLOYEE CERTIFICATION

You must read the Employee Certification statement, **sign it, and date the application.**

Misrepresentation: Any person that knowingly provides false or misleading information is subject to criminal and civil penalties.

EMPLOYER CERTIFICATION

Must be completed by your employer before submitting the application. By signing this application the employer certifies that:

1) The employee is eligible;
2) The application is legible and completed in its entirety;
3) The employee's selected plans and coverage levels are appropriate;
4) The Employer Certification section is completed in its entirety; and
5) The information presented is true to the best of their knowledge.

REQUIRED DOCUMENTATION FOR SHBP/SEHBP DEPENDENT ELIGIBILITY AND ENROLLMENT

The State Health Benefits Program (SHBP) and School Employees' Health Benefits Program (SEHBP) are required to ensure that only employees, retirees, eligible children, and eligible dependents are receiving health care coverage under the programs. As a result, the Division of Pensions and Benefits must guarantee consistent application of eligibility requirements within the plans. Employees or Retirees who enroll children or dependents for coverage (spouses, civil union partners, domestic partners, children, disabled and/or over age children continuing coverage) must submit the following documentation in addition to the appropriate health benefits enrollment or change of status application.

DEPENDENTS	ELIGIBILITY DEFINITION	DOCUMENTATION REQUIRED
SPOUSE	A person of the opposite sex to whom you are legally married.	• A photocopy of the *Marriage Certificate* **and** • A photocopy of the front page of the employee/retiree's most recently filed federal tax return* (*Form 1040*) that includes the spouse.
CIVIL UNION PARTNER	A person of the same sex with whom you have entered into a civil union.	• A photocopy of the *New Jersey Civil Union Certificate* or a valid certification from another jurisdiction that recognizes same-sex civil unions **and** • A photocopy of the front page of the employee/retiree's most recently filed NJ tax return* that includes the partner **or** a photocopy of a recent (within 90 days of application) bank statement or bill that includes the names of both partner's and is received at the same address.
DOMESTIC PARTNER	A person of the same sex with whom you have entered into a domestic partnership as defined under Chapter 246, P.L. 2003, the Domestic Partnership Act. The domestic partner of any State employee, State retiree, or any eligible employee or retiree of a SHBP/SEHBP participating local public entity, who adopts a resolution to provide Chapter 246 health benefits, is eligible for coverage.	• A photocopy of the *New Jersey Certificate of Domestic Partnership* dated prior to February 19, 2007 or a valid certification from another State of foreign jurisdiction that recognizes same-sex domestic partners **and** • A photocopy of the front page of the employee/retiree's most recently filed NJ tax return* that includes the partner **or** a photocopy of a recent (within 90 days of application) bank statement or bill that includes the names of both partner's and is received at the same address.
CHILDREN	A subscriber's child until age 26, *regardless* of the child's marital, student, or financial dependency status – even if the young adult no longer lives with his or her parents. This includes a stepchild, foster child, legally adopted child, or any child in a guardian-ward relationship upon submitting required supporting documentation.	• **Natural or Adopted Child** – A photocopy of the child's birth certificate showing the name of the employee/retiree as a parent. • **Step Child** – A photocopy of the child's birth certificate showing the name of the employee/retiree's spouse or partner as a parent **and** a photocopy of the marriage/partnership certificate showing the names of the employee/retiree and spouse/partner. • **Legal Guardian, Grandchild, or Foster Child** – Photocopies of Final Court Orders with the presiding judge's signature and seal. Documents must attest to the legal guardianship by the covered employee.

* ***Note:*** *For tax forms you may black out all financial information and all but the last 4 digits of any Social Security numbers.*

To obtain copies of the documents listed above, contact the office of the Town Clerk in the city of the birth, marriage, etc., or visit these Web sites: ***www.vitalrec.com*** or ***www.studentclearinghouse.org*** New Jersey residents can obtain records from the State Bureau of Vital Statistics and Registration Web site: ***www.state.nj.us/health/vital/index.shtml***

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DEPENDENTS	ELIGIBILITY DEFINITION	DOCUMENTATION REQUIRED
DEPENDENT CHILDREN WITH DISABILITIES	If a covered child is not capable of self-support when he or she reaches age 26 due to mental illness or incapacity, or a physical disability, the child may be eligible for a continuance of coverage. Coverage for children with disabilities may continue only while (1) you are covered through the SHBP or SEHBP, and (2) the child continues to be disabled, and (3) the child is unmarried or does not enter into a civil union or domestic partnership, and (4) the child remains substantially dependent on you for support and maintenance. You will be contacted periodically to verify that the child remains eligible for continued coverage.	• Documentation for the appropriate "Child" type as noted on page 1 **and** a photocopy of the front page of the employee/retiree's most recently filed federal tax return* (*Form 1040*) that includes the child. • If Social Security disability has been awarded, or is currently pending, please include this information with the documentation that is submitted. **Please note** that this information is only verifying the child's eligibility as a dependent. The disability status of the child is determined through a separate process.
CONTINUED COVERAGE FOR OVER AGE CHILDREN	Certain children over age 26 may be eligible for continued coverage until age 31 under the provisions of Chapter 375, P.L. 2005. This includes a child by blood or law who: • Is under the age of 31; • Is unmarried or not a partner in a civil union or domestic partnership; • Has no dependent(s) of his or her own; • Is a resident of New Jersey or is a student at an accredited public or private institution of higher education, with at least 15 credit hours; and • Is not provided coverage as a subscriber, insured, enrollee, or covered person under a group or individual health benefits plan, church plan, or health benefits plan, or entitled to benefits under Medicare.	• Documentation for the appropriate "Child" type as noted on page 1 **and** a photocopy of the front page of the child's most recently filed federal tax return* (*Form 1040*), **and** if the child resides outside of the State of New Jersey, documentation of full time student status must be submitted.

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